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THE MEDICAL JOURNAL OF AUSTRALIA

(With which "The Australasian Medical Gazette," and "The Australian Medical Journal" are incorporated.)

The Journal of the Australian Branches of the British Medical Association.

VOL. I.—3RD YEAR—NO. 17. SYDNEY: SATURDAY, APRIL 22, 1916. PRICE 6D.

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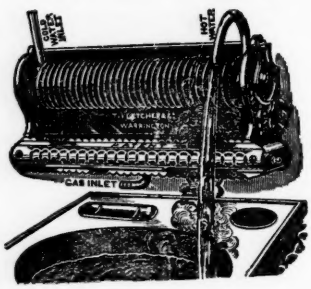

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—3RD YEAR. SYDNEY: APRIL 22, 1916. No. 17.

The Anzac Medical Association.

INAUGURATION AND FIRST MEETING.

The inaugural meeting of the Anzac Medical Association was held at the No 1 Australian Casualty Clearing Station, on November 7, 1915.

Colonel N. R. Howse, V.C, C.B. (Deputy Director of Medical Services at Anzac) was requested to take the chair. He proposed that the *Anzac Medical Association* be formed, and that the Association should hold meetings each fortnight, for the purpose of discussing scientific and other matters of general interest to the medical service. He suggested that the speakers in each discussion should confine their remarks to their personal experience and practice, as it was only by so doing that the members could be helped in their work at the front.

Major Poate seconded the motion, which was carried unanimously.

Office-Bearers.

The following office-bearers and members of the committee were elected:—

President: The Deputy Director of Medical Services, Colonel Howse.

Vice-Presidents: The Acting Directors of Medical Services and the Senior Medical Officers of the R.A.M.C., the I.M.S., and the N.Z.M.S. (Colonel Freeman, 54th Division; Lieutenant-Colonel Hearn, 1st Australian Division; Colonel Sutton, 2nd Australian Division; Lieutenant-Colonel Downes, Australian and New Zealand Division: Major Ellery, R.A.M.C.; Major Battye, I.M.S.; and Major O'Neill, New Zealand M.S.).

Members of Committee: The Deputy-Assistant Directors of Medical Services of Divisions; Lieutenant-Colonel Freemantle, 54th Division; Major Tebbutt, 1st Australian Division; Lieutenant-Colonel Millard, 2nd Australian Division; Major Carbury, Australian and New Zealand Division; also Lieutenant-Colonel Gordon, No. 1 A.C.C.S.; Captain Watson, R.A.M.C., Acting Officer in Command of the 16th C.C.S.; and Captain Husband, I.M.S.

Honorary Secretaries: Major Newlands and Major Poate.

Colonel Howse, in calling upon Major Butler, D.S.O., Regimental Medical Officer to the 9th Infantry Battalion, A.I.F., to open a discussion on "Lice," urged all medical officers to recognize the importance of preventing disease. He expressed the hope that at this and at future discussions their energies, remarks and proposals should be influenced in this direction. He regarded the regimental medical officers as the backbone of the medical service, as it was upon them that the responsibility of prevention and of early detection of disease among the men in the trenches fell. They were directly concerned with the good health of these men.

Discussion on Lice.

Major Butler, D.S.O., said: I take it that our object to-day is to assist the Deputy Director of Medical Services in evolving the most practicable scheme of lessening to as great a degree as possible—

(1) The incidence of infestation by *Pediculi vestimentorum*;

(2) and thereby of minimizing the danger of the spread of disease occasioned by their presence.

I take it that the association of the body louse with the spread of typhus fever is undoubted, and it is this fact that makes the louse question most urgent and important. The direct problem of the prevention of the introduction and spread of typhus fever does not concern us as much to-day as the steps to be taken to render its possible spread more under control by lessening the path of infection, *viz.*, the louse infestation of the troops.

We have to keep in mind the limitations of our possible procedure by the conditions under which we are placed, especially as regards the obtaining and maintaining of supplies of all necessary material. The fact that a large proportion of the men have no second set of clothes is a bar to bulk disinfection of clothing.

A brief outline of the natural history of the louse will enable us to detect some of his vulnerable points, and will supply hints as to his destruction. From a chitinous, resistent egg is hatched, in from six to eight days to five weeks or more, a minute and very vulnerable larva, which begins to feed at once. These larvæ are practically invisible, except when filled with blood, and 1½ days' starvation is fatal to them. From larva to adult takes 11 to 15 days; the adult life lasts three to four weeks. The female will lay from 100 to 150 eggs, under favourable conditions. The adult louse feeds twice a day, and will die in four days if kept without food, and is said to attach itself to a thread of clothing before commencing to feed. Heating to 100° C. kills the insect, but the ova will resist steam sterilization, unless this is very efficient.

Lice will migrate from one lot of kits or clothing to another lot, and may be found infesting floors of dug-outs and in blankets. The bite produces slight irritation, unless scratched, when it becomes very irritable. As regards the host, the men must have clothes and blankets. Men vary greatly in their habits of cleanliness, and, unless convinced of the real and undoubted danger, are prone to acquiesce in the condition as an inevitable concomitant of their surroundings, but the majority of them would readily adopt simple, efficient measures.

The following are the most practical methods at our disposal for dealing with the pest. As many combinations as possible should be used.

(1) Steam sterilization of clothes and blankets.
(2) Deposition under the seams of the clothing of some substance such as *vermijelli*, or a mixture of soft soap and crude oil, or the use of some mineral oil, *e.g.*, kerosene, petrol, etc.
(3) The use of N.C.I. powder (2% iodoform, 2% creasote and 96% naphthalene).
(4) The use of "Keating's" or other insect powders or a bag of sulphur worn round the neck.
(5) Mercurial ointment on strands of wool, worn round the neck, waist and calves of legs
(6) Hot ironing the seams of clothing.
(7) Individual search and picking of all clothing.
(8) Regular changing of clothes once a week.
(9) Regular bathing and general personal cleanliness.
(10) The use of an emulsion of ½% lysol and 20% soft soap, to be lathered on the skin and allowed to dry.
(11) The cleaning and sterilization or fumigation of blankets and dug-outs (*e.g.*, by sulphur dioxide).
(12) The immediate destruction by burning of all discarded clothes, etc.

Captain Phipson, 6th Gurkhas, wished to lay stress on the following points:—

1. That the men should be shown a louse, so as to be sure of what they were looking for.
2. That it was not a fact that the louse always anchored himself to clothing before feeding.
3. That lice, when hungry, became cannabalistic.
4. That while a louse feeds it excreted a substance attractive to flies. This might be a factor in the spread of some diseases.
5. That the louse bite was a minute roseola, not raised, not papular and not hæmorrhagic. It only acquired these characters after scratching.

He raised the question whether the louse adapted itself to the colour of its host, as he had observed that lice from Gurkhas were darker than those from Europeans.

Be believed in personal cleanliness and a daily search of the clothes, baths and, change of clothes once a week at least, and the use of N.C.I. powder.

Major Tebbutt (1st Australian Division) said that the diseases transmitted by lice were typhus and relapsing fever. Captain Archibald (at Mudros) had reported one case of the latter in an Indian from the Gallipoli Peninsula, and some couple of months before there had been a case of typhus from Anzac. Typhus was to be expected; in the last Balkan War there were 5,000 cases in hospital at Gallipoli. He thought there were two ways in which it might be introduced:—

(1) From Turkish prisoners of war, and
(2) From the capture and occupation of Turkish trenches.

All prisoners should be bathed and have their clothes disinfected immediately, and be transferred from the front as soon as possible. Trenches should be cleaned and sprayed and all dead burned as soon as the military situation would permit. He thought spraying trenches and dug-outs, etc., with mineral oil would be effective.

Lieutenant-Colonel Freemantle (54th Division) said that, in lieu of steam disinfection, he had tried steeping blankets in 1 in 20 cresol solution for 24 hours, then drying in the sun and storing them for two to four weeks before use, so that, if any ova had escaped alive and hatched out later on, the larvæ would die from inanition.

Major Battye (I.M.S.) had had five weeks' experience of the continuous use of N.C.I. powder and *vermijelli*, combined with regular bathing parades, change of clothes, etc., for his men. He was a strong advocate of disinfection by sulphur dioxide, which, if properly carried out, killed both lice and nits.

Lieutenant-Colonel Dudgeon (Advisory Committee) said that he had seen both the case of typhus and the case of relapsing fever from Gallipoli; they were undoubted. Among the Serbian troops there had been great numbers affected with these fevers, and it was noticed they were always lice-infested. He strongly recommended the Servian barrels for disinfection of clothes by steam, as being cheap, effective and easily installed and run. Sulphur disinfection was greatly used among the French troops, and proved very effective. Solar oil (kerosene, minus the benzine) was greatly used along the Suez Canal for rubbing into the seams of the clothes. Failing this, kerosene was as good.

Colonel Howse, D.D.M.S., wished first to thank Lieutenant-Colonel Dudgeon for his presence and remarks. He pointed out that for steam sterilizers water and coal were the difficulties, as even with only one "Thresh" sterilizer available, it could not be kept going continuously. He then detailed the promises he had received, which he hoped would be fulfilled some day, even though some were months old. He had been promised:—

(1) Five or seven Thresh sterilizers.
(2) Wash-houses and drying houses.
(3) Marine soap.
(4) Servian barrels.
(5) N.C.I. powder and *vermijelli* in constant supply of 4 lbs. of each per 100 men.
(6) An issue of fresh clothing for the winter.

He pointed out that the troops were living under conditions similar to a garrison, and that it was very necessary that medical officers should make a daily tour of their whole area and inspect each man's dug-out, and impress on the men the need for constant hunting and destroying of the louse.

In conclusion, he wished to thank the speakers, who had given him some very useful information and hints.

The meeting then terminated.

SECOND GENERAL MEETING.

The second general meeting was held at the No. 1 Australian Casualty Clearing Station on November 21, 1915, at 2.30 p.m. In the absence of the D.D.M.S., Colonel Howse, in Egypt, the chair was taken by Colonel Sutton, A.D.D.M.S. There were 86 medical officers present, although the weather conditions

were very unfavourable. The minutes of the inaugural meeting were read and confirmed.

Jaundice.

Major Battye, I.M.S., opened the discussion on the "Prevalent Jaundice," his observations being based on cases occurring among officers in the Indian Brigade. Dyspeptic symptoms, with abdominal distension, were a marked feature of all cases. Frothy motions, with great diminution of bile, were common. He suggested a yeast fungus as the cause of the symptoms, which were those of a gastric fermentation. He gave calomel, followed by Epsom salts, as required, and did not think anything else than dieting was required.

Captain Drake, I.M.S., based his remarks on his experience of cases among the men of the Indian Brigade, of whom 2% were affected. He referred to the typical anorexia, and remarked on the prevalence of mental depression, and also of pruritis and joint pains, which occurred in 60% of his cases. The later cases gave no history of previous dysentery, although the earlier ones did. He gave sodium bicarbonate as a routine drug. This type of jaundice did not resemble epidemic catarrhal jaundice, or Weil's disease, as there was no acute febrile disturbances, and no albuminuria.

Major Fowler, 1st L.H.F.A., said that, of the 1st L.H. Brigade, over 5% of the men were affected. During August there were no cases; in September there were 4; in October 40, and in November, to date, 56; of these, 17 were evacuated. In the course of the illness the pre-jaundice period lasted from two to four days, and was marked by a complete anorexia, flatulence, lassitude and epigastric pains and tenderness. The jaundice period lasted from 14 to 17 days, the illness during the first week being characterized by a continuance of the initial symptoms, which finally cleared up quickly. The patient developed a ravenous appetite, and could be returned to duty, although still jaundiced He had noticed a very few pale stools. One patient had splenic enlargement. As a rule, the liver was enlarged and tender, and constipation a marked feature. About 50% of the patients had never had diarrhœa at all, and the remainder had a latent period before the onset of jaundice. The average time the men had been at Anzac was three months. He considered that the infection was probably through the blood stream, and that the ultimate ramifications of the biliary tract were affected, and not only the common bile duct. It did not appear to be an infectious disease, as none of the orderlies nursing these cases developed jaundice.

Captain Sprent, 3rd Field Ambulance, had had 43 cases in the Field Hospital in the past two weeks, and 18 were treated on sick parade. There were 33 different units represented, a point rather against the disease being infectious. Twenty-two of the patients had been at Anzac for seven months, and eleven for six months; the remaining 28 men had been on shore from two to five months. Twenty-two had not had diarrhœa for at least one month before the jaundice appeared. In 34 cases there was a temperature of 99° to 102°. Nineteen patients had to be evacuated. Rest, starvation and calomel, followed by Epsom salts, were the main principles of treatment.

Lieutenant Davey, No. 1 A.C.C.S., had seen many of the patients evacuated from the "Old Anzac" area; the majority had marked gastric symptoms, were deeply jaundiced, and had enlarged and tender livers and often palpable gall bladders. Some had enlarged spleens. They were being evacuated because they had not reacted to treatment on shore, except the first few, all of whom were sent away immediately on the onset of the jaundice.

Captain Chapman, 5th Field Ambulance, had seen 150 cases since the end of September. One patient developed an acute cholecystitis. Light diet, in small amounts, and the administration of saline aperients were essential for treatment during the period of anorexia.

Captain Pern, R.M.O., 19th Battalion, had seen 45 cases in the last 20 days, and regarded any case with fever as unfavourable for treatment in the lines. The other usually reacted well, if they were taken off duty and dieted.

Colonel Freeman, 54th Division, emphasized some of the remarks of the previous speakers, and commented on the undue incidence of the illness among officers as compared with the men.

Captain Brownell, 7th Field Ambulance, instanced one case in which very acute gastric symptoms, severe epigastric pains and intractible vomiting developed. The patient became delirious on the third day. Clinically, there was nothing to be found in the abdomen to account for the symptoms, and as he became collapsed on the third day, he was sent to 16th Casualty Clearing Station, where he subsequently died.

Colonel Sutton, Acting D.D.M.S., made a few remarks in conclusion, and congratulated the speakers on the way in which they had presented the facts and extracted their deductions therefrom.

From the administrative point of view, the main conclusion arrived at was that the greater proportion of these cases could be treated on shore, instead of being evacuated, as was done when the disease first appeared.

The speakers were accorded a hearty vote of thanks by acclamation, and the meeting then terminated.

THIRD GENERAL MEETING.

The third general meeting was held at the No. 1 Australian Stationary Hospital on December 5, 1915, at 2.30 p.m. In the absence of the D.D.M.S., Colonel Sutton, through illness, the chair was taken by Colonel Begg, A.D.M.S., A. and N.Z., Division. There were 47 medical officers present, this small number being due to the departure of the 54th Division, and to stress of the military situation in part of the line.

The minutes of the previous meeting were read and confirmed.

The Treatment of Wounds.

Captain Storey, R.M.O., 13th Battalion, opened the discussion on "The Treatment of Wounds Prior to Evacuation." From the point of view of the medi-

cal officer, he considered that the less a regimental medical officer tried to do the better for the patient, save in cases of urgency or in fractures, where some fixation apparatus was necessary for safe transport. Reference was made to the lack of such apparatus in the equipment of the regimental medical officer. He regarded iodine as most unsatisfactory. It was very seldom a regimental medical officer could save life directly. The stretcher-bearers should be made thoroughly *au fait* with pressure points and the use and abuse of the tourniquet. Some attempt should be made to treat the patient's general condition, *e.g.*, by warm covering, warm drinks, etc., before sending him on to the field ambulance.

Major Battye, 108th Field Ambulance, outlined methods of treatment applicable at the field ambulance, the most important of all being treatment of shock by hot bottles or stones, blankets, hot drinks, saline infusion, injection of pituitrin or morphine and atropine, all of which were kept ready by him day and night. The necessity of catheterization should be kept in mind. As regards hæmorrhage, each case must be considered on its own merits, and no hard and fast rule could be laid down as to whether vessels should be tied at once or forceps put on and left on, or the wound packed, etc. He considered the equipment in fracture apparatus was very deficient. A field ambulance medical officer should always apply splints such as would ensure the maximum of safety with the minimum of discomfort for the further transport of the patient. As regards abdominal wounds, he considered that early operations gave the only chance; as a rule, the intra-abdominal hæmorrhage was very severe. He also thought the early removal of bullets advisable. Good results had been got by the hypochlorous dressings.

Lieutenant-Colonel Gordon, No. 1 A.C.C.S., referred to the work done in the clearing station. One of their chief troubles was that patients were received with very few, if any, particulars as to the exact nature of the wound and what had been done. In their treatment they attempted to prevent the introduction or development of sepsis. In the dressing tent, the only solution used at the time was *eusol* and 0.5% hypochlorous acid solution, which had proved most satisfactory for a dressing for the first two to four days. Patients with wounds in the chest were always kept in hospital for several days, and then stood transport well. It was not necessary to do anything more for the patient than to keep him absolutely quiet. He advocated operation at the earliest possible moment for abdominal wounds. He excised in one piece the whole length of the damaged intestine.

Major Poate, No. 3 Field Ambulance, endorsed some of the remarks of the previous speakers, and referred to the necessity of everything possible being done for the patient in a field ambulance, before he was sent on, especially in cases of fractures. It was the preliminary dressing of the wound and the adjusting of suitable splints that was of supreme importance for the future welfare of the patient. He referred to the use of *eusol*, and advocated its adoption by regimental medical officers, in preference to iodine as a first dressing for all wounds.

Major Croll, No. 2 L.H.F.A., referred to some remarks of the previous speakers, and complained of the great handicap that a deficient water supply imposed on an ambulance.

Colonel Begg, in his concluding remarks, spoke of the difficulties that had to be contended with, especially as regards transport of patients with compound fractures of the lower extremity. One method in frequent use was to tie the foot to the handle of the stretcher, and then to carry the man head first down the gully, thus getting automatic extension of the injured limb. He also believed in an early operation for an abdominal wound, as practically all the patients died without operation, while a few were undoubtedly saved by early operation.

The meeting terminated with a vote of thanks to the speakers.

FOURTH GENERAL MEETING.

The fourth general meeting was held at the No. 1 Australian Casualty Clearing Station on December 19, 1915. In the absence of all members of the Committee, the chair was taken by Major Campbell (No. 1 A.C.C.S.), S.M.O., Anzac. There were present Captain Gauntlett, 13th C.C.S.., Captain Barton, No. 1 A.C.C.S., Captain Kneebone, No. 1 A.C.C.S., Captain Stocker, I.M.S., Lieutenant Mackay, No. 1 A.C.C.S.

Duties of Regimental Medical Officers.

Captain Stocker, I.M.S., opened the discussion on the sphere of duties of the regimental medical officer, and reviewed these duties under peace and war conditions.

Captain Gauntlett strongly advocated the use of Watson Cheyne's paste by the regimental medical officer as a first dressing for wounds. Captain Barton also joined in the discussion, which was concluded with a few remarks by the Chairman, Major Campbell.

A unanimous hope was expressed that the next meeting of the Association might not be held at Anzac.

FIFTH GENERAL MEETING.

The fifth general meeting was held at the No. 2 Australian General Hospital, Cairo, on January 23, 1916, at 3 p.m. The President, Surgeon-General Howse, V.C., C.B., was in the chair, and there were about 30 medical officers present. The minutes of the previous meeting were read and confirmed. It was decided to elect as Vice-Presidents the Officers in Command of the No. 1, No. 2 and No. 3 Australian General Hospitals.

Operations of Convenience.

Major Poate opened a discussion on "Operations of Convenience under Active Service Conditions." He reviewed, first of all, the class of cases entering the surgical beds under his charge at No. 2 Australian General Hospital as being an average sample of the present surgical work of a general hospital. Many of the cases were of a trivial nature, that would not prevent a man carrying on ordinary duty; a soft-hearted medical officer enabled the patient to get away from work for a spell, ostensibly for an opinion or advice at a base hos-

pital. An instance of this was the case of a man, who had had a testicle atrophied for four or five years, and another man, who had his leg broken eleven years before, and although it was soundly set in excellent position, he used it as an excuse to dodge work.

There were also many minor ailments being referred to the base, which could and should be treated quite well in field ambulance or lines of communication units, *e.g.*, ingrowing toe-nails, septic fingers, hydrocele, etc. However, when the cases were sifted through, it was found that many men were in need of surgical attention for conditions commonly met with in civil life, *e.g.*, hernia, hæmorrhoids, appendicitis, etc. It is more with the idea of the selection of such cases that they had to deal with, and as the Director of Medical Services wished to issue some principles for guidance on this question, it was necessary to be more or less dogmatic in considering the matter.

After discussing each complaint, the conclusions arrived at were:—

1. All cases of inguinal hernia and appendicitis were to be operated on at once. The wounds should heal by first intention, enabling the patient to be discharged from General Hospital to Auxiliary Hospital or Convalescent Depôt in two to three weeks, and have a further period of four to six weeks' convalescence before returning to duty.

2. Varicocele did not need operation. All that was necessary was to give the man a couple of suspensory bandages and to send him back to duty.

3. Varicose Veins.—Extensive varix rendered men unfit for further service. Only slight cases should be operated upon, and then only after careful consideration.

4. Hæmorrhoids.—Only marked cases, with a history of continued discomfort, should be operated on.

5. Hydrocele.—Aspiration of the fluid should be sufficient in the majority of cases. Operation was only to be considered if the condition recurred rapidly and repeatedly after tapping.

6. Semilunar Cartilage.—A man, who had had definite and repeated locking of the knee-joint and synovitis, was seldom fit for duty within six months of the operation. It was, therefore, wise to refuse operation at the front. If the man was unable to carry on any further duty after treatment of the synovitis, he should be sent back to Australia.

7. Deformities of the feet, such as hammer toe, *hallux valgus*, etc., should not be operated upon at all, except perhaps a very few selected cases of hammer toe, which were obviously causing definite disability.

8. Fractures.—Operations for fracture should not be undertaken unless there was some very urgent and definite need for surgical interference. The majority of fractures involving the larger joints rendered a man unfit for further service.

Colonel Ryan (Consulting Surgeon, A.I.F.) recounted his experience of the suitability for further service of the class of patients under consideration, and fully agreed with Major Poate.

Lieutenant-Colonel Martin, Officer in Command of the No. 2 A.G.H., considered that all patients with knee injuries should be returned as unfit for further service, and the greater number of those suffering from varicose veins, as the cases were very unsatisfactory.

Lieutenant-Colonel Gordon, No. 2 A.G.H., as a result of experience at the front, was of opinion that the majority of men after operation were unsatisfactory for service, as the scar provided the man with an excurse to shirk work. He considered it would be best in such condition as varicose veins, knee injuries, etc., to keep the men at work until there was no question as to anything further being got out of them, and then to invalid them.

Major Hurley, attached to the staff of the Director of Medical Services, considered that the question as to whether the man was going to be fit for full service in a reasonable time should be the main factor in deciding on operative treatment, except in emergencies.

Major Quick, No. 1 A.G.H., also spoke on the question raised by Major Hurley. He wished that some figures could be obtained to determine whether it were a sound business proposition to lay a man up in Egypt for two or three months or more, with the none too certain prospect, in certain cases, of his being fit for full duty again. The proportionate value of a man and the service he was likely to render in the future should be an important factor in deciding whether an operation should be undertaken in those cases.

Surgeon-General Ford outlined the treatment accorded men in the regular army, where a great deal depended on the age and service of the soldier.

Surgeon-General Howse, in conclusion, commented on the psychical effects of an operation and of a scar on the patient, and considered that sufficient attention had not been paid to this aspect of the question. He considered operative treatment for varicocele was no longer justifiable. He hoped to be able shortly to issue some guiding principles in regard to operative treatment for cases such as those under discussion.

The meeting then terminated with a hearty vote of thanks to the speakers.

Reviews.

COMPARATIVE ANATOMY.

"The Structure of the Fowl,"[1] by Dr. O. Charnock Bradley, Principal of the Royal Veterinary College, Edinburgh, is a bright little book, produced in an admirable style. It has been written primarily for the use of students of agricultural science and veterinary science, but should also prove acceptable to beginners in zoology and comparative anatomy.

The introduction deals with the modifications of avian structure related to flight and to the large size of the bird's egg, and these have made their mark on nearly every part of the bird's anatomy. The question of the origin of domestic fowls from the Indian jungle-fowl, *Gallus ferrugineus*, is also discussed here, briefly, but in an interesting way.

The skeleton of the fowl is clearly and accurately described. In discussing the muscular system, attention has been confined to the muscles of flight and to the perching mechanism. In the chapters on the alimentary, reproductive and renal systems, a concise account of the microscopical, as well as the gross, anatomy of these parts has

[1] The Structure of the Fowl, by O. Charnock Bradley, M.D., D.Sc., M.R.C.V.S., 1915. London: A. & C. Black, Ltd.; Cr. 8vo., pp. 153, with illustrations. Price, 3s. 6d.

been given, as it is obviously necessary for anyone who will have to deal with pathological conditions in the fowl to know the normal structure of the parts. Short but useful accounts of the anatomy of the respiratory, circulatory and nervous systems, together with that of the organs of special sense, appear in their proper place, while the last third of the book is devoted to an elementary account of the development of the fowl. The book is brightly illustrated by more than seventy figures and diagrams, many of which are new, but of variable merit.

Hospitals.

ROYAL PRINCE ALFRED HOSPITAL.

The annual meeting of the Governors and subscribers of the Royal Prince Alfred Hospital, Sydney, was held under the Presidency of His Excellency the Governor of New South Wales on April 10, 1916. In moving the adoption of the annual report, Sir Thomas Anderson Stuart discussed many matters of first-rate importance. The contents of the report will be summarized in a subsequent issue.

Sir Thomas started his speech with a reference to the general utility of the hospital. During the year 1915 there were 396 beds open for use, and an additional 18 had been brought into service for special cases. With 414 available beds, the daily average number of patients in the hospital had been kept down to 379.6. This number was 15 less than that obtaining in the previous year, and Sir Thomas explained that the reduction was a gain, both from an administrative and from an economic point of view. Extra patients caused an undue amount of extra trouble to the nursing staff. The cost per bed was approximately £112 per annum, so that the saving on the 15 beds was around £1,700. He pointed out that the Board had been able, with the money at its disposal, to pay expenses for the reduced number of patients and no more. There would have been difficulty in finding the necessary money for the additional 15 patients.

Nationalization of Hospitals.

In the next place, Sir Thomas drew a comparison between the weekly cost per patient in the Royal Prince Alfred Hospital and that in a military hospital. The cost was £2 2s. 9d., while at the Randwick Military Hospital it was £8. He admitted that there were conditions special to a military hospital, but claimed that the disparity between 42¾s. and 160s. was so great that the Board might well congratulate themselves on their efficiency and economy. "If the £8 per week, or anything approaching that sum, is to be taken as what would happen under the system of nationalized hospitals," he said, "we may very well pray to be spared from any such change in hospital methods."

Civil or Military Hospitals for Soldiers.

Dealing, in a later part of his speech, with the hospital and the war, he informed his audience that some years back the Board, regarding the possibility of a European war, had made certain preparations for this eventuality. When the great war broke out the whole of the resources of the Royal Prince Alfred Hospital was offered to the Defence Department. It was pointed out that 100 beds were available, and, later, this number was increased to 150. Finally, they offered to take in 500 soldiers, by dint of squeezing beds in the wards and using the verandahs. The necessary beds, bedding and equipment had been obtained, when the Director-General of Medical Services informed them that 100 beds would be occupied. This was done so that the returned soldiers might have had, if they had been sent to the hospital, the advice of the best physicians and surgeons and the most highly organized medical, surgical and nursing arrangements. "As these beds," he continued, "have not been made use of, we cannot but feel that the establishment of special military hospitals at great cost is a policy not beyond question." The only special ward, which was made use of by the military authorities, was a small ward containing eight beds. This ward was offered for the treatment of patients suffering from epidemic cerebro-spinal meningitis, and for research in connexion with this disease.

Night Clinics.

The treatment of patients in the venereal clinics was begun on January 11, 1915, and, unfortunately, it had been an overwhelming success in regard to numbers, but, fortunately, also an overwhelming success in regard to results. The number of persons, male and female, treated at the clinic was close on 2,300. These patients overran the institution, and the doors had to be closed, in order to limit their number. Sir Thomas expressed the opinion that this state of affairs was a disgrace and a shame to Sydney, and a perpetual menace to its people. He did not wonder that there were 500 soldiers constantly in the venereal compound connected with the military camp. He pleaded for a greater number of venereal night clinics connected with the public hospitals. An additional 18 beds had been provided for children between the ages of three and eight years suffering from congenital and other forms of syphilis. In regarding the question from the financial aspect, he emphasized the waste of keeping 500 men in idleness and worse in the compound. He reminded his audience that if the men were discharged the service, as was often the case, the cost of their training and equipment would be thrown away.

Anti-Tuberculosis Campaign.

In dealing with the work of the Anti-Tuberculosis Dispensary, he referred to a report which Mr. Epps, the Secretary to the Board, had drawn up. This report had been considered and approved by the Board. It dealt with the American "Social Service" scheme in connexion with hospitals. The system helped to bridge over the gap between the condition of being a hospital patient and the condition of being a self-supporting member of the community. Its activities included the education of the masses in daily domestic hygiene, the best methods of feeding, dressing and living generally, and the like.

The Need for Isolation Wards.

Sir Thomas Anderson Stuart made reference to the outbreak of scarlatina and morbilli among the patients of the hospital, and the necessity of closing the hospital to visitors for a period of two months This outbreak was responsible for an increase in the average number of days spent in the wards by each patient from 19.81 to 21.57. He urged that it was imperative that more adequate provision should be made for the isolation of persons suffering from the notifiable infectious diseases. He held that it was a scandal that a city as great as Sydney was not provided with a properly organized and conveniently situated fever hospital. The Government had done nothing, in spite of the fact that the defects were brought to its notice year after year. In this connexion, he drew attention to the fact that the whole hospital system in the State required reorganization. There were five hospitals with less than one occupied bed each. He pointed out that this state of affairs led to unnecessary extravagance.

The Medical Staff and the War.

After reviewing the work accomplished in the special departments, he passed on to the consideration of the effect of the war on the efficiency of the hospital. When war was declared, the Board determined that it was their duty to keep the positions of those members of the staff, who desired to serve the Empire with the combatant forces, vacant until their return. Of the 40 honorary medical officers, there were 13 on active service; of the resident medical officers, 20 were at the front; of the nursing staff, a like number has joined the Expeditionary Forces; and of the members of the lay staff, 22 were under arms. He referred in sympathetic terms to the death of Dr. Verge, who died in Egypt, and whose name appeared on the Roll of Honour placed in the main hall by the kindness of the new Honorary Treasurer, Mr. Hordern. He announced that the Board had determined not to countenance permanent appointments to the Honorary Staff during the currency of the war, so that when the war was over and the men came back, they would not find places, for which they would have liked to have been candidates, filled permanently in their absence.

The increase in price of drugs and foodstuffs occupied his attention for a few moments, and he then detailed the changes in the constitution of the Board. The resignation of the Honourable Mr. Kater from the office of Honorary Treasurer, which he had filled so well for over 15 years, was referred to with expressions of deep regret. In conclusion, he cast a glance through the history of the Hospital, and claimed that it had developed from a good-sized hospital into a great one,

The Medical Journal of Australia.

SATURDAY, APRIL 22, 1916.

The Anzac Medical Association.

On November 7, 1915, a band of keen, scientifically-minded medical men, serving in important positions in the Gallipoli peninsula, met in the Australian Casualty Clearing Station for the purpose of establishing a medical society, to be composed of the medical officers of the various units in the British Army. These men recognized that their efficiency could be increased and marked benefit for the troops under their care would accrue if they could discuss their experiences and exchange confidences at periodical meetings. The Anzac Medical Assocation was formed, and a useful discussion on the body louse in its relation to typhus fever took place. The Association, under the able presidency of Surgeon-General N. R. Howse, V.C., consisted from the first of over 100 members (see *The Medical Journal of Australia*, February 5, 1916, p. 121). At the second meeting held in the same place as the first there were 86 members present, a percentage rarely reached in the best organized scientific society in civil life. It must not be forgotten that the members in Anzac were living a life entailing a supreme output of energy under conditions as trying and nerve-racking as can well be imagined. How often does a man in ordinary circumstances pull off his boots, slip on his smoking-jacket and light his pipe after a hard day's work, and consign the meeting of his scientific society to the territory across the Styx! The century of medical officers in Anzac had thrown off this comfortable leisure, and had stolen the time to improve their work as guardians of the health of our fighting soldiers.

The history of the Anzac campaign explains the drop in the attendance at the third meeting, when Captain Storey was the first speaker in the discussion on the treatment of wounds prior to evacuation. We know that the men, who were not present, were prevented from following their inclinations by more urgent calls. A fortnight later the position appears to have been practically incompatible with the holding of a meeting. None of the members of the Committee were able to free themselves from military duty, and the brevity of the record speaks eloquently of the difficulties obtaining at the time in the peninsula. No more pathetic sentence can be imagined than the concluding one: "A unanimous hope was expressed that the next meeting of the Association might not be held at Anzac." And it was not. Over six weeks elapsed before the fifth meeting was summoned in Cairo, and, in the meantime, our gallant, high-spirited colleagues had left the stormy beach when the army was withdrawn in that wonderful achievement of December 19 and 20, 1915.

During the past few months we have been in the fortunate position of being able to publish articles written by men, who have had valuable experience at the front and in Egypt. These articles have been instructive to those who may be called upon to perform like services. They have been of importance to the civil practitioner, and they constitute valuable contributions to scientific writings. The records which we publish in the present issue are less academic, but more direct. They will be valued as historical records and prized for the practical advice, which they contain. Men, who are capable of founding a debating society under such conditions as those which obtained at Anzac, and of conducting the meetings with the whistling of the bullets and shells in the air, are men of whom Australia may well be proud. They are born to do great things.

HOSPITALS AND THE STATE.

The appeal recently made to the Victorian Government by the members of the Melbourne Hospital Committee for increased financial aid, some of the figures and facts concerning the Royal Prince Alfred Hospital in Sydney and the march of events connected with the Tasmanian hospitals may be utilized with advantage in reviewing the position taken up by the votaries of nationalizing hospitals. The arguments adduced by the Labour Party in favour of this social revolution appear to consist mainly in the claim that the masses have a right to free medical and surgical attention under the most favourable conditions, and in the assumption that maxi-

mum efficiency and economy can be attained when the State takes over the responsibilities and control of all persons concerned in the care of the sick. Incidentally, the various Governments appear to hanker after the position of being masters of everything. There is but little doubt that the public can be gulled into the belief that the reasons why the ministries want to alter the existing state of affairs lies in a real concern in the welfare of the sick. The man in the streets shuts his eyes to the suggestion that political capital might be made out of ostensible anxiety concerning the provision of treatment for the sick, and that the vote-snatchers know little and care less about the management of these essentially eleemosynary institutions.

The deputation from the Melbourne Hospital have supplied some poignant facts to the Minister, which tend to show that unless there is something to be gained by it in political life, the Government is not much concerned about the welfare of a great hospital. The Melbourne Hospital cost £270,000 to build, and the Government supplied one-ninth of that sum, namely, £30,000. The number of patients under treatment has increased year by year until the daily average has reached 360 and the annual expenditure now exceeds £40,000. In spite of these hard facts, the Government subsidy has decreased from £15,000 30 years ago to £10,250. When faced with pending insolvency, the Committee applied to the Government for increased help. It was justified in doing so, since the institution was providing, free of cost, maintenance and nursing, and the medical profession was giving, without remuneration, free medical and surgical treatment to the sick who were not in a position to pay for this elsewhere. The reply given by the Premier last August was that further assistance could not be provided by the Government, and that the Board was advised to use the money accumulated in the endowment or reserve funds. It has been pointed out that the endowment funds were not reserve funds at all, and that the Committee had no power to utilize the endowment money for maintenance purposes. In the case of the Royal Prince Alfred Hospital, we learn from the powerful speech delivered by Sir Thomas Anderson Stuart at the annual meeting that the income just covered the expenditure for the year 1915, since the Board had reduced the number of beds in constant occupation. We are justified in asking whether, in view of this experience, the funds necessary for the proper upkeep of the great hospitals would be forthcoming if the Governments were to take these institutions over. We have called attention in the past to the difficulties experienced by the Hobart Hospital Board in commanding funds requisite for the maintenance of the hospital at a level in consonance with the requirements of the times.

With this doubt whether State Governments would provide sufficiently for hospitals, if nationalized, Sir Thomas Anderson Stuart associated a still more potent argument against nationalization. He pointed out that the maintenance cost at the Randwick Military Hospital per bed is practically 3¾ times that at the Royal Prince Alfred Hospital. He made allowance for the fact that there are special circumstances connected with a military hospital, which would increase the cost of its administration and maintenance, but even if a large margin be allowed for these special conditions, the figures for the military hospital are not encouraging to the scheme of handing over the hospitals to the State Governments.

It may therefore be argued with justice that before the politicians press forward their plans for taking over the hospitals, the public must have evidence that those in charge would not be required to administer the institutions on wantonly extravagant lines and with an insufficient supply of money. These two factors must necessarily lead to a restriction of the utility of hospitals.

It is unnecessary for the present to marshal forth the other arguments against nationalization of hospitals. It may become necessary at a later date to enquire into the arguments of the "other side," in favour of exploiting medical men for political motives, or in the alternative handing over the hospital work to salaried medical officers, to the exclusion of experienced and matured practitioners, whose services the Governments could not possibly afford to command. It may then be advisable to enquire whether there is sufficient evidence in favour of the proposed new order of things to justify the public in assuming that efficiency would not be sacrificed by requiring hospital physicians and surgeons to supply to the rich and poor alike a commodity, which

yields to them their livelihood, but which they are prepared to give to those who cannot pay for it. These and many other arguments against nationalization of hospitals may be put aside for the moment, until evidence is produced that the Governments have grasped the elements of hospital management and the principle of economy without sacrifice of efficiency.

INFANTILE PARALYSIS IN NEW ZEALAND.

The history of the New Zealand epidemic of acute anterior poliomyelitis is furnishing some striking lessons in epidemiology. If the returns of the Health Department of Auckland be studied, it will be seen that two distinct epidemics have been running simultaneously, and that, while the one in the city has now come to an end, the other, spread over a larger country district, had not shown any tendency to cease up to the beginning of the month. In regarding figures of the incidence of any notifiable disease, it is necessary to bear in mind that two factors of error may falsify the returns. In the first place, some of the cases may not be notified. The failure to notify may be due to disinclination on the part of medical practitioners to comply with the law. This neglect hampers the public health authorities considerably, and impedes the work of attempting to check the spread of the epidemic. In some cases, the failure may be due to the mildness of the condition and the consequent neglect on the part of the patient or his relatives to apply for medical assistance. Lastly, it may be due to a failure on the part of the medical practitioner to recognize the affection. In the case of anterior poliomyelitis, a wrong diagnosis should not be made under usual conditions, more particularly during the course of an epidemic. The second source of fallacy is to be sought in the delay in notification. When a disease begins indefinitely and insiduously, medical advice is frequently not sought until the condition has existed for some time. Under these circumstances, the health authority is hampered in the attempt to trace the source of infection, owing to the misleading information in regard to the date of the first manifestations. Usually, the curve plotted out of the number of cases notified in the abscissa and the days or weeks in the ordinate follows a regular sweep, and, as the epidemic approaches its termination, the curve tends more and more to coincide with the horizontal line. In the case of the recent outbreak of infantile paralysis in New South Wales, the curve was so irregular that it is certain that one or both sources of error were interfering with a correct impression of the position. In New Zealand, the health authorities have been fortunate in securing the wholehearted support and assistance of the general practitioner. The curve of the city epidemic remained steep and comparatively regular up to the 26th of February. After this date the upward direction of the curve diminished with increasing rapidity, so that within the first ten days of March the end of the epidemic became quite apparent. In regard to the outbreak in the country, the curve takes the form of an almost straight line since January. The line does not show any tendency yet to become rounded off, or, in other words, to approximate the horizontal line, and, consequently, it may be said that the end of the epidemic is not yet in sight. Some information can be obtained as to the course of an epidemic by the mortality returns, provided that the figures are large enough and also that the variations in the fatality of the disease has been found to follow a definite rule in previous epidemics. In the present instance, the numbers are too small to be reliable. With a total incidence of 443 spread over both city and country, the mortality has been about 10%. A closer analysis, however, reveals that this percentage does not hold good for any given time or for any group of cases In the city there were 16 deaths among 175 patients, which gives a case mortality of 9.14%. In the country districts, there were 28 deaths among 268 patients, giving a case mortality of 10.41%. This mortality appears to be slightly lower than that of other epidemics, especially those observed in England.

SIGHT AND COLOUR VISION TESTS.

We are pleased to note that the wool tests for the detection of colour sense defects have been eliminated from the tests prescribed by regulation for the mercantile marine, in so far as New South Wales is concerned. On April 14, 1916, the amendments to the regulations under the "Navigation Act, 1901," and the "Navigation Amendment (Regulations) Act, 1904," were published in the Government *Gazette*, No. 65. The amendments concerning the sight tests are included in Appendices M and N. It is prescribed that sight tests must be conducted under the strict personal supervision of the examiner. A careful record must be kept of all mistakes made by the candidate in the form vision test. A record must also be kept of candidates who have passed the tests. In regard to colour sense, the wool tests are abolished, in compliance with the recommendation of the Colonial Secretary. These tests have been discontinued in Great Britain by order of the Board of Trade since January 1, 1916. In the place of the wool tests, the lantern tests are to be used. A candidate who mistakes red for green or green for red, either with the large aperture or the two smaller apertures of the lantern, will be considered to have failed in colour vision. If the only mistakes be the calling of white "red," provided that after the candidate's attention has been directed to the mistake no further mistakes be made, he may be passed for colour vision. If a candidate makes any other mistake with the lantern, *e.g.*, if he calls white "red" repeatedly or red "white" at all, or confuses green and white, he is to be told that the decision as to whether he has passed or failed will be communicated to him later.

Abstracts from Current Medical Literature.

PATHOLOGY.

(145) The Culture of the Meningococcus.

G. Faroy and Chavaillon have designed a new medium for the cultivation of the meningococcus (*C.R. Soc. Biol.*, Paris, August, 1915). This medium was prepared to avoid the use of ascitic fluid which cannot be always obtained when required. They add 20 c.cm. of white of egg removed from the egg with aseptic precautions to 100 c.cm. of sterile horse serum. The mixture is well shaken to mix the contents. They prepare a broth containing 2½% agar which is rendered alkaline to the extent of one part of soda in 50,000 of jelly. One part of the albuminous fluid is added to three parts of the melted jelly. The mixture is cooled to 50° C., decanted into test tubes and cooled. The culture medium can be used in connexion with the various sugars. The medium gives good results, and the organisms grow freely. The authors regard the physical characters of the medium as superior to those of ascitic agar. In collecting the horse serum, care must be taken that it is quite free from hæmoglobin.

(146) Micrococci from the Blood in Cases of Enteric Fever.

Lebrun and Portier relate the results of their bacteriological examinations of the blood from a large number of soldiers invalided with enteric fever (*C.R. Soc. Biol.*, Paris, August, 1915). On the day after their arrival in hospital 10 c.cm. of blood have been withdrawn with aseptic precautions from the arm. This blood has been mixed with 250 c.cm. of a medium composed of equal parts of broth and bile. After 24 hours' incubation, subcultures have been made into broth and on agar. If the subculture has been positive, sowings have been made into milk, glucose broth, mannite broth and lactose broth. They find that a micrococcus appears in 24% of their cultures. The micrococcus has been isolated alone or in conjunction with the typhoid organism. In 14% of their cases it has appeared with the typhoid bacillus. The coccus stains intensely with Gram's stain, and ferments none of the sugars. The micrococci are sometimes in pairs, more often in masses, rarely in tetragons, and never in chains. Litmus milk is at first turned red and later decolorized. A clot appears in the milk in 28 hours, which undergoes liquefaction. They believe that the coccus is present in the blood, since it can be invariably isolated if the hæmoculture is practised a day or two later in the same case, and since these cases often show abscesses in the thyroid and parotid glands and in the testicle. The organism is of great toxicity, and three-fourths of the patients affected have died. Antityphoid inoculation has no influence on the severity of these cases.

(147) Emphysematous Gangrene.

S. Costa and J. Troisier have isolated a number of anaerobic bacteria with characters intermediate between those of the bacillus perfringens and the bacillus of malignant œdema from cases of gaseous gangrene (*C.R. Soc. Biol.*, Paris, August, 1915). The bacillus perfringens is characterized by its immobility, by the habitual absence of spores, and by its fermentative behaviour towards sugars and proteins. The bacillus of malignant œdema is recognized by its mobility, by the presence of spores, by its slight fermentative action on the sugars without the formation of gas and by its characteristic colonies on Veillon's medium. They have separated five races of bacteria belonging to the group of bacillus lyticus. These are all anaerobic, and stain positively with Gram's stain. They all form oval subterminal spores, and are actively mobile. They show colonies on Veillon's medium similar to those of the bacillus of malignant œdema. They ferment media containing glucose, lævulose, maltose or sucrose with formation of gas. They ferment mannite in all cases, though two races form gas and three do not. They differ in their effects on milk and on white of egg. Some cause odours to arise from their cultures, while others form no odorous substances. Some cause intense hæmolysis, while others have no action on erythrocytes. They are all pathogenic, but in varying degrees.

(148) Melanomata.

W. H. D. Stevenson describes the microscopical appearances of 15 melanomata examined during the last four years (*Indian Journ. Med. Research*, July, 1915). The origin of malignant melanomata is usually assumed to be from pre-existing benign melanomata, such as moles and pigmented warts. A few cases have been recorded in which the growths have arisen from the matrix of the nails and from the pigmented skin of the anus, penis and vulva. Two cases of this type are described. In one case the growth occurred on the right lower eyelid, and in the other at the side of the nail of the little finger. Melanomata resulting from injury are rare in Europeans. Such traumatic melanomata occur not infrequently on the foot in Asiatics. The fifteen tumours described have been all situated on the heel or the sole of the foot. In five cases there has been a history of some prolonged irritation at the site of the growth. In the remaining ten cases there is no special history or injury. The ages of the patient have been over forty in all but two cases, in which the patients have been 29 and 30 years old. Microscopically, the tumours exhibited an alveolar arrangement in twelve cases. No alveolar structure has been seen in three cases. The lymphatics were involved in ten cases. The tumours of the second group showed large spheroidal or spindle-shaped cells, with many giant cells among them. The question of their identity with the better-known tumours of the first group is open to question. Some remarks are offered on the source of the pigmented cells.

(149) Mycotic Invasion of the Myocardium.

T. D. Hurley describes a unique lesion of the heart in a case of systemic blastomycosis (*Journ. Med. Research*, January, 1916). The primary site of infection in these cases is either pulmonary or cutaneous, so that the lesions in the deeper organs are necessarily metastatic. The organs which have been found to contain these metastases from skin or lung are, in order of frequency, bone, spleen, liver, brain and meninges, lymph nodes, kidneys, pleura, prostate, pancreas, heart, pericardium, spinal cord, epididymis, eye, larynx, appendix and testicle. This tabulation is based on the records of 21 complete autopsies. Cardiac lesions are thus uncommon, and the specimen described is stated to be unique, on account of the size, number and location of the cardiac changes. The heart was removed from a man, aged 61 years, admitted in May, 1914, to hospital, with symptoms of pulmonary tuberculosis. Bacilli were not found. Abscesses formed in the scalp and bones of the arms and thoracic walls. The patient died in January, 1916. At autopsy, the condition was recognized as due to blastomycosis. Lesions were found in the skin of the face, scalp, chest and arm. The pericardial cavity contained numerous dense, fibrous adhesions between the thickened pericardium and the heart, among which was much fibrin and many collections of purulent material. The largest of these was in communication externally with a subcutaneous abscess, and internally with a necrotic area in the anterior wall of the left ventricle of the heart. The heart weighed 420 gm. It was light reddish brown in colour, though its surface showed grayish-yellow areas, necrotic in the centre and indefinite in outline. The necrotic areas extended deeply into the myocardium, and in one case involved the endocardium. The interior of the heart presented a surface covered with small white nodules, in some of which crater-like depressions occur. Microscopically, sections showed typical blastomycotic infection. The larger lesions were made up by fusion of small foci. The lesions were suggestive of tuberculosis, showing endothelial proliferation, the formation of giant cells and central necrosis. Within many of the giant cells, as well as free among the infiltrating cells of inflammation, were more or less numerous blastomycetes of the sclerotic type. Relatively few presented the appearance of budding.

(150) Antitoxin for the Bacillus Œdematiens.

M. Weinberg and P. Seguin have prepared an antitoxin for *bacillus oedematiens* by injecting sheep with small doses of the highly virulent toxin (*C.R. Soc. Biol.*, Paris, November, 1915). The serum of the sheep acquires the capac-

ity of neutralizing the toxin *in vitro*. One-twentieth cubic centimetre of toxin, which constitutes two lethal doses for a guinea-pig, is neutralized by one-five hundredth cubic centimetre of serum. The mixture is left in the incubator for one hour at 37° C. before injection. One cubic centimetre does not neutralize two fatal doses of the toxin of the bacillus of malignant œdema. The serum is also capable of preventing the effects of the injection of living cultures of *bacillus oedematiens*. One-tenth cubic centimetre of the serum protects against one cubic centimetre of a fresh broth culture. No local lesion occurs. When the amount of serum is limited to one-hundredth cubic centimetre, a local inflammatory lesion occurs. With less serum, the death of the guinea-pig is delayed. The serum has no protective power against cultures of the bacillus of malignant œdema, or against cultures of *bacillus perfringens*. The preventive effect of the serum when injected into the animal is much less marked. Two cubic centimetres are required, when injected twelve hours previously, to protect against two fatal doses of the toxin. The curative action is only seen when one centimetre of the serum is injected within five minutes of the administration of the toxin. When an interval of thirty minutes has elapsed, no dose of serum saves the animal. The toxin must therefore be rapidly bound to the tissues.

PÆDIATRICS.

(151) Intravenous Injections and Aspirations.

Helmholz (*Amer. Journ. of Dis. of Children*, September, 1915) points out that the various methods of obtaining blood from infants for diagnostic purposes have hitherto proved very unsatisfactory. For example, scarification gives tissue juice as well as blood, and there is frequently contamination. Again, the usual method of obtaining blood from the scalp, jugular, and other veins is very difficult, and failure is frequent. There is one place, however, in the longitudinal sinus in the area of the anterior fontanelle, which affords better facilities for aspiration, injection and transfusion than any other. The sinus increases in size towards the posterior part of the head. The puncture must therefore be performed at the posterior margin of the fontanelle. The course of the sinus does not vary, and its walls are rigid, and cannot be pushed aside. Accidental puncture of the brain is of no practical importance. The author uses a special apparatus, which he describes in detail, for purposes of transfusion and saline infusion, and a special head holder.

(152) The Ammoniacal Diaper in Infants and Young Children.

Zaborsky (*Amer. Journ. of Dis. of Children*, December, 1915) finds that the "ammoniacal diaper" is of frequent occurrence. The odour of ammonia is usually faint, but occasionally the concentration is so intense as to cause a characteristic irritation of the skin, *e.g.*, inflamed areas on the inner side of the thighs, genitals, buttocks and lower abdomen, and sometimes over the whole diaper area. Vesicles and blebs may also appear on the prepuce and other definite points of contact with the diaper, such as at the meatus after circumcision has been performed. Enuresis and ammoniuria go together, and the latter is frequently the precursor of pyelitis. The association of the ammoniacal diaper with the exudative diathesis is frequently found. The onset is abrupt, and the course irregular and indefinite. The worst cases are found in children from one to four years of age, especially during the winter months. In infants, the condition is limited to the artificially fed, especially where cow's milk and cereal decoctions are used. Orange juice and alkalies aggravate the condition; high fat mixtures have a varying effect. Constipation is usual. Bacterial action has been excluded as a causal factor. Infants with digestive disturbances give a relatively high ammonia nitrogen content, and older children frequently give a surprisingly high content, but a high ammonia nitrogen content does not necessarily accompany ammoniuria. On no occasion did a urine obtained directly from a child contain free ammonia, which is present in the ammoniacal diaper. The condition is really due to the presence of an alkali in the diaper or bedding. The alkali remaining after the use of strong soap in washing the clothing with insufficient rinsing afterwards. Any condition increasing the alkalinity of the urine, such as the administration of alkalies or orange juice, or the alkalinity of the bedding, etc., as insufficient rinsing or washing in alkaline water, tends to cause the "ammoniacal diaper," especially where there is a high ammonia nitrogen content of the urine.

(153) Whole Milk for Infants.

Viving (*Practitioner*, November, 1915) is a strong advocate for the use of whole milk (cow's) in the artificial feeding of infants. The usual arguments against such feeding are: (1) Whole milk is unsuitable, and babies cannot take it, and should not be given it, because of a difficulty in digesting a milk containing a higher protein content than human milk, because of the mechanical difficulty in dealing with the tough, firm clot of cow's milk, and because the child finds it harder to metabolize the constituents of cow's milk than those of human milk. (2) It is unsound practice to be constantly drugging a child with citrate of soda, which is added to overcome the admitted mechanical digestive difficulty. (3) Whole milk feeding is too costly. It has been proved by many investigators that a high protein content is not necessarily a source of digestive trouble in the infant. Again, prolonged heating, or the addition of citrate of soda, removes the mechanical difficulty. Figures, too, show that whole milk feeding is less costly than feeding with the ordinary artificial foods. Citration of the milk would tend to prevent scurvy, while the sterilization of the milk shuts out the danger of tuberculosis, which is always present in the ordinary dried milks. The following rules are useful in applying this method of feeding. (1) The milk must be citrated, 2 grs. of citrate of soda being added to each ounce of milk. At the age of six months this amount is halved. (2) The amount of milk given depends on the child, its size and stomach capacity, and is to be determined by the condition of the stools, the amount of sleep, the weight, and the physical and mental development of the infant. A baby in winter requires more than in summer, when more fluid is necessary. (3) Where artificial feeding is resorted to from birth, milk diluted half and half should be used at first, and at the end of three or four weeks, whole milk should be substituted. (4) Care should be taken to avoid constipation by using liquid paraffin or equal parts of the confections of sulphur and senna.

(154) Familial Syphilis.

Jeans (*Amer. Journ. of Dis. of Children*, January, 1916) has made an exhaustive study of 100 cases of syphilis in children themselves and of the remaining members of each family. The previous histories of the parents, their clinical appearance and the reaction of their blood to the Wassermann test were all taken into account. (1) Germ transmission of hereditary syphilis has not been proved. There is little evidence to show that it occurs. (2) It is highly probable that all the mothers of syphilitic children have been infected with syphilis. Of 85 mothers of syphilitic children, 86% gave a positive Wassermann reaction. All of the remaining patients but six gave a history of infection or treatment, or both. Five of these six patients were examined at least ten years after the birth of their last syphilitic child, when the infection was probably dying out. (3) Eighty-seven per cent. of the mothers denied all knowledge of the infection. The mothers were, for the most part, infected during the latent stage of the father. (4) Of 331 pregnancies in 100 families, 30% were abortions, 9% still-births and 61% living births. Of the babies born alive, 24% had died. Of the living, 80% had syphilis. (5) Of the total number of mothers, 90% were presumably syphilitic, and, although 10% seemed free from the disease, there was no proof that they were so. The total syphilis in these families amounted to 93% of the entire family. (6) For the most part, the families followed Kassowitz's rule, *i.e.*, decreasing grades of infection with each successive pregnancy. (7) In the case of syphilitic mothers bearing healthy children, it is probable that the infection in the mother is localized in places where it is not readily transmitted. (8) The idea that there are different strains of spirochaeta (neurotropic, etc.) receives some support from the study of these families. (9) Transmission to the third generation, though not proved, is distinctly an occasional probability.

British Medical Association News.

SCIENTIFIC.

A clinical meeting of the New South Wales Branch was held at the B.M.A. Building, 30-34 Elizabeth Street, Sydney, on April 15, 1916, Dr. Sinclair Gillies, the President, in the chair.

Dr. W. F. Litchfield demonstrated two cases of *hypoplastic* or *honeycomb teeth* in children the subjects of *rickets*. He referred to an article by Dr. Harvey Sutton (*The Medical Journal of Australia*, October 30, 1915, p. 412), in which the author dealt with this condition. Dr. Harvey Sutton had made some original observations, although the affection had been described before. It had, however, never been dealt with in so comprehensive a manner. The first full description of hypoplasia of the teeth had been given by Colyer. Dr. Litchfield's first patient was a girl aged 9½ years. She had been brought to the hospital on account of a habit spasm, which had some relation to chorea. The teeth affected were the incisors, canines and the first molars. The child came from London. The second patient was a girl aged 7½ years. She, too, was an English child. The incisors, canines and first molars were involved in this case as well. The distal half of the teeth was thin, discoloured and serrated. There was a marked degree of deficiency of calcification. The canines were short and stumpy, and the molars pointed. The affected teeth were not more liable to caries than normal teeth; in fact Dr. Litchfield was inclined to the opinion that they were slightly less liable to caries. They were harder than ordinary teeth.

The interesting points of the cases were that the patients were both immigrants. The teeth affected were those which were undergoing calcification during the "rickety" period. Hypoplasia of the teeth was not due to syphilis. Congenital syphilis was very common in Australia, whereas this condition was very rare among Australian children. He emphasized the point that some diseases were not due to syphilis. He was of opinion that Dr. Harvey Sutton had overstated the frequency of congenital syphilis. Hypoplasia was not due to stomatitis. He did not follow Dr. Harvey Sutton in his statement that the hardness of the British water resulted in a greater prevalence of rickets than in Australia. Rickets in its severer forms was very rare in Australia, but the lime salt content of the Australian water varied greatly in different parts and in different cities. The next point of interest was that both children were brought to him for nervous symptoms. The one had a nervous spasm. This spasm consisted of a sudden snort, followed by a hollowing out of the abdomen. This had been going on for about four months. He had treated the condition as he would have treated chorea, by rest in bed with surrounding screens. At the end of a week the spasm had ceased. He hoped that the cure would prove permanent. In the second child there were epileptiform seizures. The attacks were not true epilepsy. The fits lasted for about two or three minutes; the child did not actually lose consciousness, but appeared to be oblivious of what was happening. The rickets had been cured in both patients. In conclusion he expressed the opinion that children of a nervous habit were more prone to rickets than children of a stable nervous system.

In the discussion, Dr. Ralph Worrall was not disposed to doubt the frequency of this dental affection among rachitic children observed by him when he was in Ireland. In those days they had not trained themselves to look for this affection, and consequently had not recognized it.

Dr. Sinclair Gillies did not think that hypoplasia was as common as Drs. Harvey Sutton and Litchfield would have them believe. In London rickets in its severest forms was extremely common, but he had not seen a very large number of these cases. In his student days the condition was regarded as being due to mercury, and the teeth were called "mercurial teeth." If they were really manifestations of rickets, he asked why they were not more common.

In his reply, Dr. Litchfield agreed with Dr. Worrall that the honeycomb teeth were not detected as such in the past. He quoted Dr. Harvey Sutton in support of the contention that the affection was very common among ricketty children. Dr. Harvey Sutton had met with it in 11% of the immigrant children examined, not in 11% of children affected with rachitis. He was of opinion that if the condition were looked for, it would be found frequently among these children.

Professor D. Welsh demonstrated a series of specimens of somewhat diverse pathological conditions. Before describing the specimens themselves, he called the attention of the members to the methods in use of preparing the specimens for demonstration purposes. A great improvement had been registered in the preservation of the tissues and in the retention and bringing out of the natural colours. But a still greater advance had been made in the mounting of the specimens. By cutting into the bone or other tissue, a more instructive specimen was obtained, and it became possible to appreciate the nature of the process in a way that would be impossible were the intact specimen mounted. If the pathologist were inclined to be generous, he could retain the better half for his own museum, and give the other to another museum.

1. The first specimen was one of an *adeno-carcinoma of the ovary* in a girl aged 15 years The patient had been under the care of Dr. Dunlop, to whom he was indebted for the clinical record and for the specimen. The patient had complained of an increase in the size of the abdomen during a period of two months. She had had continuous pain for two days. Prior to this there had been no pain. Menstruation had commenced at the age of 13 years, and had been irregular. A tumour had been removed by operation. The peritoneal cavity was found to be filled with clear fluid. Secondary nodules were seen scattered all over the pelvis. The patient was still alive, but the issue was not in doubt. A microscopical section of the tumour revealed a typical adeno-carcinoma. The proliferation was rather wild, and large spaces were seen, some of which were filled with colloid material. The naked eye appearances of the tumour were demonstrated. The growth was a large one. Professor Welsh stated that the patient was the youngest girl, with a cancer of the ovary he had seen

2. The four bone specimens demonstrated formed a series illustrating the three common types of primary sarcoma of bone.

(*a*) The first specimen of the series was a knee joint involved in a *myeloid sarcoma*. The patient was a married woman aged 32 years. Eight months before she was seen by Dr. McKelvie, she had felt a dull aching pain in the left knee, which came on insidiously. At the same time she noticed a swelling of the inner side of the knee. The pain became worse, and six weeks before she was seen became paroxysmal. From that time she had been compelled to keep her bed. At about the same time she experienced jerky spasms of the muscles of the leg. The pain was relieved at first by extension, but later it persisted in spite of all endeavours. From the specimen it was seen that the growth had started from the central part of the bone, and had extended, eroding the bone, especially in the region of the condyle. The process had destroyed and expanded the bony tissue. Microscopically it consisted of spindle cells, with large giant cells in considerable numbers.

(*b*) The next specimen was from a man aged 27 years. The patient came to Dr. Abbott with a history of a swelling in the leg for three months. The swelling had been lanced two weeks before, and one week before a needle had been passed into it. There was no record of the result of these procedures, but Professor Welsh had no doubt that nothing happened. There was no pain and no loss of weight. The thigh was slightly wasted, and there was very little movement in the knee joint. The tumour had started in the upper end of the tibia on the inner side. It had eroded and destroyed the whole of the inner aspect of the bone. The periosteum had been invaded, but there was no formation of new bone tissue. On microscopical examination it was found to be a sarcoma of large multinucleated spindle cells. This form of growth was spoken of as a *large spindle and mixed cell sarcoma*. It was impossible to arrive at the differential diagnosis without the aid of the microscope in these tumours.

(*c*) The third specimen was also one of *large spindle and mixed cell sarcoma*, this time involving the femur. The

patient was a man aged 43 years. The patient is said to have suffered a "pathological" (probably spontaneous) fracture of the right femur 14 months before, when lifting a heavy weight. He had not been able to walk for nine months. There was considerable pain in the leg. The specimen showed that the tumour was less hæmorrhagic than the others exhibited. There was some thickening of the bone, which was probably due to callus. Microscopically the tumour was seen to consist of spindle and mixed cells.

(*d*) The last specimen of the series was one of *round cell sarcoma of the left humerus*. The patient had consulted Dr. O'Gorman Hughes. She was 14 years of age. Eleven weeks before she had been struck on the left arm, and had found difficulty in using it afterwards. Four weeks later, when getting out of a buggy, she supported herself on her left arm, which snapped in two. A radiogram taken after the occurrence revealed the bones in apposition, and some doubtful evidence of a growth. Later, a second radiogram was taken, and the evidence of a new growth was then conclusive. Intrascapular amputation of the arm was performed by Dr. O'Gorman Hughes. A differential leucocyte count, taken before the operation, yielded the following result: Polymorphonuclear leucocytes, 55.5%; lymphocytes, 27.5%; large mononuclear cells, 13%; and eosinophile cells, 4%. The specimen showed that the fracture was complete, and that the growth had started in the bony tissue and had invaded the periosteum. A good deal of callus had been thrown out. In discussing the pathology of the case, Professor Welsh expressed the opinion that the growth had been present longer than eleven weeks, which was the period between the first injury and the operation.

3. Professor Welsh then demonstrated a case of *intrathoracic aneurysm* in a man aged 51 years. The aneurysm had ruptured through the anterior thoracic wall. The patient had been admitted to the Royal Prince Alfred Hospital, under the care of Dr. Horsfall, complaining of a swelling in the chest, accompanied by severe pain, shortness of breath, cough and attacks of loss of memory. He had felt quite well six months before. Since that time he had had intermittent pain in the upper part of the thorax and left shoulder. The swelling had appeared two weeks later, and had continued. The pain had been continuous for four months, and had prevented him form doing his work. He had had a cough for about the same time. There had been dyspnœa for two weeks. At times, the patient felt as if he would suffocate, and he noticed that from time to time he had no recollection of what had taken place the day before. Thinking the swelling was a large abscess, he had applied poultices at irregular intervals. The swelling increased in size, and the pain became more severe after this. He had had syphilis 23 years before. He was a smoker and heavy drinker. He had been married for 21 years, and had seven children. The first child was still-born, and the second died shortly after birth. The remaining children were alive and "healthy." There was a swelling extending from the left border of the sternum to the mid-axillary line, and from the second to the seventh rib. It measured 18 inches in circumference. The skin was not discoloured, but was adherent to the swelling. A thrill was felt over the whole of the left side of the chest. There was dulness on percussion over the same area, except in the neighbourhood of the first intercostal space. No breath sounds were heard, save over the first intercostal space. The patient remained in hospital for 43 days, during which time the tumour continued to increase in size. The blood pressure measured at the radial artery did not undergo any appreciable variation. Fourteen days before death a small tumour formed to the right of the swelling; the skin became reddened and utimately became ulcerated. Dark blood began to ooze from the ulcerated area 24 hours before death. This continued for four hours. Half of an hour before death hæmorrhage again occurred, and was more copious than before. It was accompanied by severe pain. At the autopsy the left lung was found at the upper part of the pleural cavity. The pericardium extended from the second rib to the diaphragm, and was adherent to the chest wall. It was filled with clear fluid. Professor Welsh had not cut through the specimen, and was therefore not in a position to say in what part of the heart the aneurysm had its origin. He proposed to do this soon, and promised to bring the mounted specimen up to a subsequent meeting of the Branch.

Dr. C. Ayres referred to Dr. O'Gorman Hughes' case. He had made the radiographic examination, and had found at first a moderate amount of swelling in the upper arm. It was difficult to determine whether the swelling was due to the injury or to a growth. The radiogram lent strong support in favour of disease. The callus could be seen on each side of the site where the fracture had been. A few days later he took a second shadow picture, and could then detect that the growth was protruding into the soft tissues. The patient had done remarkably well since Dr. O'Gorman Hughes had operated. The speaker raised the question whether these sarcomatous growths of bone affected joints early. He then turned his attention to the differential diagnosis. It was often extremely difficult to make a clinical diagnosis between periosteal sarcoma and myositis ossificans. He recalled a case of Sir Pearce Gould's, in which the mistake was corrected by radiography. In myositis ossificans there was a definite outline to the bony growth, whereas in periosteal sarcoma the edges were more diffuse. Dr. Ayres exhibited a series of skiagrams, illustrating the appearances in abscess of bone, benign cysts, hydatids of bone, gummata of bone, syphilitic disease involving bone and tubercular disease of bone.

Dr. E. H. Binney wished to thank Professor Welsh for his valuable demonstration. He considered that the surgeon would benefit greatly by these demonstrations. In discussing the characters of malignant disease of bone, he contrasted the specimens shown with the changes met with in syphilis or simple inflammatory conditions. In malignant disease there was no involvement of the periosteum, as in syphilis or osteo-myelitis. Tubercle produced considerable thickening of the bony tissue around the disease. The diagnosis was difficult to make from clinical manifestations. They had been told that X-rays assisted in clearing up these points.

Dr. W. F. Litchfield referred to a peculiar type of bone tumour. In old men spontaneous fracture was often associated with cancer of the prostate gland. In a case he had observed there was a spontaneous fracture of the clavicle co-existing with carcinoma of the prostate. In these cases, the prostatic tumour was primary, and the secondary growth selected out the clavicle or other bone, and led to spontaneous fracture. This association had been dealt with by an author, writing in the *British Medical Journal*, some time ago.

Dr. Ralph Worrall prefaced his remarks by stating that he never came to a meeting of the Branch without learning something new. He had learned of the condition spoken of as hypoplasia of the teeth, and he had learned from Professor Welsh's splendid specimens. He recognized the value of the methods of preserving and presenting the specimens, and thought that the shelves should be so arranged that the student should be able to see them from all sides. He considered that it would be well if every surgeon and gynæcologist would send Professor Welsh every specimen they could obtain, in order that his collection at the University might be enriched to the greatest extent. In reference to the adeno-carcinoma case, he called attention to a serious omission in the account. There was no record of the condition of the other ovary. This condition was nearly always bilateral. Bland Sutton had expressed the opinion that adeno-carcinoma of the ovary was almost invariably a secondary growth, the primary tumour being in the gall bladder, intestine or other organ. He spoke of malignant growths developing as a secondary condition to a papillary condition of the ovary. In referring to the aneurysm case, he recalled Clifford Allbutt's saying that aneurysm of the aorta resulted from the imbibition of large quantities of beer and the occurrence of great vascular strain. He asked Professor Welsh whether there was any information available as to whether the patient had been treated for his syphilis.

Dr. Sinclair Gillies expressed the hope that Professor Welsh would not give away the second half of the aneurysm specimen after it had been cut. He considered that this one would lose in value if the complete aneurysm were not kept. In regard to the adeno-carcinoma of the ovary, he mentioned that he had seen a case in a still younger child. The growth had been removed, but had recurred eight months later. He also pointed out that it appeared to him possible that the tumour in Dr. Morton's case was a periosteal sarcoma, involving the shaft.

Professor Welsh replied briefly. He explained to Dr. Ayres that, as far as his experience went, the joints were never involved primarily in sarcoma of bone. The nearer the starting focus of disease to the joint, the earlier would the joint involvement be. He maintained that until the bone was cut into it was impossible to determine what the exact nature of the tumour was. In reply to Dr. Worrall, he said that he did not share the view of Bland Sutton regarding the origin of ovarian cancers. On the other hand, he pointed out that tumours of the ovary frequently gave rise to secondary growths in the peritoneum. The epithelium burst through the surface of the serous membrane, and took on a very exuberant growth in the process. Dr. Brady had asked him informally to describe the process of preserving the colour of the specimens. The fresh specimen was placed in a solution of formalin, with nitrites added to it. The colour was intensified in this stage by the formation of NO-hæmoglobin. Then the specimen was transferred to spirit to revive the colour, and finally it was preserved in a weak dilution of glycerine, or in sugar and water. He considered that Dr. Sinclair Gillies's suggestion that the growth might be periosteal in the case referred to was not unlikely. He proposed to study the case more closely.

Dr. A. J. Brady demonstrated three somewhat unusual foreign bodies connected with the ear. As a rule, foreign bodies were introduced into ears by children or by their friends. His first case was that of a child of 2½ years, who had a discharge from the ear. There was a granulomatous condition. The child had been running with a piece of stick in its mouth, and had fallen. The wood had pierced the soft palate. The child's father had pulled the stick out. On curetting the granulations in the auditory passages, he felt a hard substance. On closer examination, he found that a short piece of wood was firmly embedded in the middle ear. It had probably passed into the middle ear from the mouth, through the glenoid cavity. His second case affected a boy of five years. It was stated that the child had had a running ear all his life. He had been in hospital, and curetting had been carried out without success. On inspection, he had discovered a dark object, which proved to be hard and like bare bone on palpation with a probe. He therefore opened up the mastoid, and, to his surprise, came across a piece of slate pencil, which was buried in the bone for a considerable distance. There was no history explaining how the slate pencil had gained an entrance. The third foreign body was less uncommon. It was a bead. It proved extremely difficult to get out. The parents had tried to get it out, but had only succeeded in pushing it farther in. A medical man had attempted to remove it, but had failed. It was found in the middle ear, and much difficulty was experienced in catching it up with ear forceps prior to passing a hook behind it. Dr. Brady spoke earnestly about the dangers of meddling with ears with foreign bodies retained. More damage could be done by an unskilled attempt to remove a foreign body than if it were left alone, provided that it was clean and not living. He advised the use of a syringe and warm water as a routine method at first. When the foreign body was a living thing, great pain would be caused, and it was essential to interfere without delay. The instillation of some mineral oil would kill an insect, such as a beetle, and the effect of the application would be instant relief of the pain. He related a case of a man in whose ear a big brown beetle had entered.

Dr. E. H. Binney stated that everything that Dr. Brady spoke at the meetings was worth listening to. He considered that the warning not to poke about in the ear was timely and important.

Dr. Hill asked Dr. Brady whether a foreign body in the ear caused coughing. Dr. Brady assented to this. He explained that coughing and a choking sensation were by no means uncommon. He thought that a reflex was set up through the Vidian nerve, Meckel's ganglion and the pneumogastric.

MEDICO-POLITICAL.

A meeting of the Council of the Victoria Branch was held at the Medical Society Hall, East Melbourne, on April 13, 1916, Dr. A. V. M. Anderson, the President, in the chair.

In regard to a letter circulated among medical practitioners by the recently formed Musicians' Union, enquiring of the recipients the terms on which they would be willing to act as medical officers to the Union, under conditions applicable to Friendly Societies, it was determined that members approached in this manner should present the Model Lodge Agreement.

The Librarians reported that a number of journals were missing from the sets in the library, and, as a consequence, the volumes could not be bound. It was decided to publish a notice in *The Medical Journal of Australia*, asking members to assist the Librarians in this matter.[1]

Public Health.

THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the week ending April 8, 1916:—

	Metropolitan Combined Districts.		Hunter River Combined Districts.		Remainder of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Enteric Fever ..	12	0	3	0	44	3	59	3
Scarlatina	54	0	4	0	90	1	148	1
Diphtheria	78	2	8	1	90	1	176	4
C'bro-Sp'l Menin.	0	0	0	0	1	0	1	0
Infantile Paralysis	4	1	3	0	5	0	12	1
Pul. Tuberculosis	31	3	0	1	0	0	31	4

SMALL-POX IN NEW SOUTH WALES.

In the week ending April 16, 1916, three fresh cases of variola have been notified in the Newcastle district. Two of these cases came to light on April 12, and one on the following day.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending April 9, 1916:—

	Metropolitan.		Rest of State.		Total.	
	Cs.	Dths.	Cs.	Dths.	Cs.	Dths.
Diphtheria	91	8	54	0	145	8
Scarlatina	10	0	16	0	26	0
Enteric Fever	2	0	12	1	14	1
Pulmonary Tuberculosis	15	9	9	1	24	10

There have been six cases of anterior poliomyelitis reported during the week, of which two were in the metropolis. The number of cases of epidemic cerebro-spinal meningitis recorded was 7, including three cases within the metropolitan area.

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending April 8, 1916:—

Disease.	No. of Cases.
Diphtheria	18
Scarlatina	5
Enteric Fever	30
Pulmonary Tuberculosis	10
Infantile Paralysis	2
Ankylostomiasis	2
Malaria	2
Erysipelas	1
Puerperal Fever	2
Cerebro-Spinal Meningitis	1
Total	73

[1] See page 354 of this issue.

THE HEALTH OF WESTERN AUSTRALIA.

The following notifications have been received by the Health Department of Western Australia during the week ending April 1, 1916:—

Disease.	Perth. Cases.	Fremantle. Cases.	Rest of State. Cases.	Total. Cases.
Enteric Fever	4	0	6	10
Diphtheria	4	3	11	18
Scarlatina	0	0	1	1
Pulmonary Tuberculosis	2	0	6	8
Erysipelas	0	1	0	1
C'bro-Spinal Meningitis	0	0	1	1
Infantile Paralysis	0	0	1	1

Vital Statistics.

VICTORIA.

The Government Statist has published an abstract of the vital statistics of the State of Victoria for the quarter ending December 31, 1915, in the *Victoria Gazette*, under date March 14, 1916.

Population.

The estimated population on June 30, 1915, was 1,426,415. On September 30, 1905, it was 1,423,418. This represents a decrease of 2,997 persons. The natural increase in the population was 4,433. A large number of emigrants were members of the Australian Expeditionary Force.

Births.

The number of males born during the quarter under review was 4,360 and of females 4,125. The total number of births during the year 1915 was 35,010. In 1911 the number was 23,044, in 1912 it was 35,817, in 1913 it was 35,978, and in 1914 it was 36,225.

Marriages.

The number of marriages contracted during the final quarter of 1915 was 3,492. This brought the number of marriages for the year 1915 to 12,832. The number has varied from 11,088 in 1911 to 11,830 in 1914.

Deaths.

The number of deaths registered within the State during the quarter was 4,141, 2,283 being of males and 1,848 of females. The total number of deaths registered during the year was 15,823. This would give a mortality rate of 11.09 per 1,000 of population, calculated on the population as estimated on June 30. The crude death-rate was lower than in any previous year. In 1914 the rate was 11.53, in 1913 it was 11.11, while in the preceding years it varied between 11.45 in 1909 and 12.94 in 1903. The number of deaths registered in Melbourne and suburbs during the year was 8,574; in Ballarat and suburbs it was 712; in Bendigo and suburbs it was 658; and in Geelong and suburbs it was 482. The actual number of deaths in Melbourne and suburbs has varied during the five-year period from 7,615 (1911) to 8,622 (1912).

Of the causes of death, some interesting information is published. The figures given refer to the four cities of Melbourne, Ballarat, Bendigo and Geelong, with their suburbs. They are entered separately, and are, unfortunately, not compared with the corresponding figures of previous years, save in connexion with a few diseases. Moreover, no figures for the whole State are given. In the following, the number of deaths caused by each group of diseases refer to Melbourne and suburbs. Diseases of the heart and blood vessels, as usual, heads the list. There were no less than 1,381 deaths from these causes. They include 755 from organic diseases of the heart, 267 from cerebral hæmorrhage, 139 from atheroma and other diseases of the arteries, 58 from acute endocarditis, 13 from pericarditis, 20 from angina pectoris and 45 from embolism and thrombosis. Malignant disease, entered generically as cancer of the various organs, appears 750 times. Tuberculosis killed 643 persons. In 527 instances the disease was pulmonary. While pulmonary tuberculosis was more common in males than in females, the reverse was true of acute miliary tuberculosis, tubercular meningitis, *tabes mesenterica* and disseminated tuberculosis. The frequency of deaths from pulmonary tuberculosis shows a tendency to diminish, but the curve indicates that, with the exception of the one point for 1915, the variations work both ways.

Of the other infective diseases, epidemic cerebro-spinal meningitis comes first, with 267 deaths. Diphtheria caused 134 deaths, pertussis caused 63, acute rheumatism 38, septicæmia 36, syphilis and influenza 32 each, enteric fever 17, morbilli 12, erysipelas 11, tetanus 8, scarlatina and dysentery 6 each, and malaria and gonorrhœa one each. In addition, there were 396 deaths due to pneumonia, and 322 from broncho-pneumonia, 143 from chronic bronchitis and 39 from acute bronchitis. The frequency of deaths from diphtheria, enteric fever, morbilli, influenza and erysipelas was lower, and that of deaths from scarlatina, pertussis and hydatids was higher than the average number during the five-year period.

Deaths from chronic nephritis numbered 494, and from acute nephritis 41. Diarrhœa and enteritis killed 353 children under two years of age and 102 individuals over this age. Premature birth accounted for 359 deaths, congenital debility for 203 and other diseases peculiar to infancy for 95. Congenital malformations are entered 88 times. Among the causes of death during the state of pregnancy, accidents appear 17 times. There were 23 instances of puerperal septicæmia, and two of *phlegmasia alba dolens*. The frequency of death associated with pregnancy appears to be slightly lower than the average of the past five years.

SYDNEY AND NEWCASTLE.

The Government Statistician of New South Wales has issued the returns of the vital statistics for the month of March and for the first quarter of 1916 in the Government *Gazette* of April 14, 1916. The figures for the metropolis of Sydney and for the Newcastle district are dealt with separately.

Births.

The number of births registered in Sydney in the month of March was 1,767. This is equivalent to an annual birth-rate of 27.79. This is the lowest birth-rate for March since the year 1912, and is considerably below the average for March in the previous five years. The birth-rate for the quarter was 6.84 per 1,000 of population, which is equivalent to an annual rate of 27.36. The average for the corresponding quarter in the preceding five years was 2.6% higher. The illegitimate birth-rate during March was equal to an annual rate of 1.64, as compared with 2.10, which was the average for the same month in the preceding five years. Of the total number of births, 314, or 18%, took place in hospitals and other public institutions. The number of births registered in Sydney of infants whose mothers do not reside within the metropolis is not given.

Deaths.

The total number of deaths recorded in the metropolis was 665. Of these, 116 were of infants under one year of age, and 168 were of persons of 65 years of age or over. The equivalent annual death-rate was 10.45. The average death-rate for March in the previous five years was 9.95. The death-rate was higher than the average for all age-periods, save that of the first year of life. The infantile mortality was 66 per 1,000 births, while the average for the previous five months of March was 73. The oldest persons whose deaths were recorded during the month were two aged 90, one aged 91, one aged 92, one aged 94 and one aged 104 years. No less than 46% of all the deaths took place in hospitals and other public institutions. The death-rate for the quarter was equal to an annual rate of 10.04.

The causes of death are given in two tables, the first dealing with the deaths registered during March, and the second dealing with those registered during the quarter. In the first, the number of deaths due to diseases associated with the cardio-vascular system numbered 98. These included 56 due to organic diseases of the heart, 26 to cerebral hæmorrhage, five to atheroma and three to aneurysm. There were 94 deaths due to diseases of the respiratory system. Of these, 47 were due to pulmonary tuberculosis, 21 to pneumonia, 14 to chronic bronchitis, and five to broncho-pneumonia. The total number of deaths from tuberculosis was 61. A comparison is drawn between the number of deaths from pulmonary tuberculosis and miliary tuberculosis in the month of March each year since 1907. The

figure given is 50, while the average was 32.6. Similarly, the total number of deaths from pneumonia and broncho-pneumonia was 26, as compared with the average figure of 19.8. The bronchitis figure of 15 compares unfavourably with the average figure of 10.1. The number of deaths from malignant disease was 59, which is but slightly above the average for March. Bright's disease caused 42 deaths and acute nephritis six. The frequency of nephritis as a cause of death was markedly increased. In regard to the infective processes, as mentioned above, tuberculosis caused 61 deaths, and lobar pneumonia 21. There were 73 deaths due to diarrhœa and enteritis. There were 11 deaths from enteric fever, and a similar number from diphtheria (exclusive of one from "croup"); seven deaths from infantile paralysis, three from cerebro-spinal meningitis, three from pertussis, two from septicæmia, two from syphilis, and one each from morbilli, scarlatina, and acute endocarditis. Of the fourteen deaths associated with the puerperal condition, six were attributed to puerperal septicæmia, and one to the result of an illegal operation.

Among the causes of death during the first quarter of 1916, there were 316 instances of diseases of the cardio-vascular system, including 179 of organic diseases of the heart, 72 of cerebral hæmorrhage, and eight of endocarditis. Cancer caused 172 deaths, pneumonia 74 and broncho-pneumonia 29. The number of deaths due to diarrhœa and enteritis was 244, of which 209 were of infants under two years of age. Tuberculosis killed 134 persons, including 106 from pulmonary tuberculosis. The number of deaths from enteric fever was 36, that from diphtheria 33, from cerebro-spinal meningitis 13, from simple meningitis 14, from pertussis 11, from morbilli nine, from scarlatina seven, from septicæmia four, and from dysentery two. Bright's disease was responsible for 133 deaths.

NEWCASTLE AND DISTRICT.

The birth-rate in the Newcastle district during the quarter was equal to an annual rate of 36.44 per 1,000 of population. During the month, 13 of the 173 infants born were illegitimate. The births were more numerous than the average for the corresponding month during the previous five years. The number of deaths registered during the month was 53, which is equivalent to an annual rate of 10.8 per 1,000 of population. The number of deaths registered during the quarter was 200, which is equivalent to an annual death-rate of 13.60.

The chief causes of death during the quarter were as follows: Diarrhœa and enteritis caused 33 deaths, of which 25 affected children under two years of age. There were 31 deaths due to affections of the cardio-vascular system. Malignant disease caused 23 deaths. Of the principal infective diseases, enteric fever caused eight deaths, tuberculosis of the lung six, acute endocarditis three, pneumonia five, broncho-pneumonia three, septicæmia two, pertussis and diphtheria one each, and cerebro-spinal meningitis also one.

THE PREVENTION OR MITIGATION OF ACUTE ANTERIOR-MYELITIS.

The Board of Health of Victoria, having taken powers to adopt drastic measures in the attempt to stem the spread of epidemic cerebro-spinal meningitis (see *The Medical Journal of Australia*, March 25, 1916, p. 274), has now obtained similar powers in connexion with acute anterior poliomyelitis. The following announcement has appeared in the *Victoria Gazette* of April 12, 1916:—

> The Governor in Council of the State of Victoria, having, by an Order, dated the 29th day of February, 1916, directed that the provisions contained in section 173 of the Health Act, 1915, as amended by the Health Act, 1915 (No. 2), No. 2810, be put into force in Victoria, the following Regulations for the prevention or mitigation of the dangerous infectious disease known as Poliomyeltis (Infantile Paralysis, Epidemic Paralysis, Spinal Palsy), that is to say:—
>
> (1) Short Title.—These Regulations may be cited as the "Poliomyelitis Regulations, 1916."
>
> (2) Interpretation.—"Board" means the Board of Public Health.
>
> "Council" means the council of any municipality, including the cities of Melbourne and Geelong.
>
> (3) On receipt of notification of a case of poliomyelitis, the council shall immediately take steps to have the infected person removed to a hospital or isolated at his own residence to the satisfaction of the Officer of Health, and shall cause inquiries to be made into the whole circumstances of the case, including sickness amongst animals and into the general sanitary environment of the premises wherein the patient resides.
>
> (4) The council shall take such action as is necessary to secure the destruction of the nose and mouth discharges of infected persons, and such persons shall be kept in isolation until released on the authority of the Officer of Health.
>
> (5) The council shall take such action as is necessary to secure that contacts residing in the same premises as the patient shall have their throats and noses disinfected, and such contacts shall submit to such treatment as the Officer of Health specifies and for such period as he directs.
>
> (6) The council shall cause the premises wherein the infected person resides to be disinfected to the satisfaction of the Officer of Health, and all insanitary conditions to be remedied forthwith, including the removal of accumulations of manure.
>
> (7) The council shall in every case of poliomyelitis furnish a report to the Board as soon as possible after the notification of the case is received, and such report shall include particulars as to source of infection, contact with other cases, sickness amongst animals, measures taken to prevent the spread of disease and all other matters that will aid the Board in taking action to safeguard the public welfare.
>
> (8) Every council and its officers are hereby authorized, required and directed to superintend and see to the execution of these Regulations, and to provide for the supply of medicines and other substances for the prevention or cure and for affording persons afflicted by or threatened with poliomyelitis, such medical or other aid as may be required.
>
> (9) Any person who fails to comply with any of the foregoing Regulations, or is guilty of any neglect or disobedience thereof, is, by section 388 of the Health Act, 1915, thereby guilty of an offence against that Act, and is liable to a penalty not exceeding Twenty pounds, and to a penalty not exceeding Five pounds nor less than Twenty shillings for each day during which such offence is continued, besides any cost or expenses which may be incurred in remedying his default.
>
> Dated at Melbourne this twenty-ninth day of March, 1916.
>
> By order of the Board of Public Health,
> T. W. H. HOLMES, Secretary.
>
> Approved by the Governor in Council,
> 5th April, 1916.
> F. W. MABBOT,
> Clerk to the Executive Council.

Naval and Military.

The following appointments have been gazetted on April 6, 1916:—

William Foster Simmons, to be Major, A.A.M.C.

Cedric William Whiting, to be Captain, A.A.M.C.

The promotion of Quartermaster and Honorary Lieutenant G. E. Sykes to Quartermaster and Honorary Lieutenant in

the Permanent Service of the Australian Army Medical Corps (dated July 1, 1915) has been announced in the *Commonwealth Gazette* of April 13, 1916.

On April 15, 1916, Sir Phillip Sydney Jones, M.D., F.R.C.S., President of the New South Wales Medical Board, celebrated his eightieth birthday. We wish to convey to him our heartiest congratulations, and to express the hope that good health and continued activity may wait on him for many years. The achievements of his life's work speak for themselves, and are so well-known that they need no special record to bring them to the notice of Australian practitioners. His connexion with the Sydney University, his work in regard to the prevention of tuberculosis, and his immense influence and guidance in educational matters, have contributed even more powerfully than the distinction of knighthood to make his name a household word. May he long continue with us!

The first report of the Federal Departmental Committee, appointed to investigate the causes of death and invalidity in the Commonwealth, has been issued on March 15, 1916. The report deals with enteric fever, and contains a mass of information. The claims on the space in our columns preclude the publication of an analysis of this report in the present issue. It is proposed to publish this analysis next week.

Correspondence.

LIFE INSURANCE POLICIES.

Sir,—Would you permit me to write regarding an article on life insurance in your issue of April 15? I have three sons engaged in the R.A.M.C. in Egypt, and when they were lads I took out life policies for them, ten to twenty years ago. On their taking up war services, I inquired on what ground the policies were in these circumstances, and if extra premiums were payable. The reply of all the offices was that no extra premiums were charged on policies issued in pre-war days; consequently none payable on my policies. The offices in which I was interested are home companies, the policies having been issued when resident in Scotland; these offices are the Caledonian, Rock, Equitable (London), Edinburgh and Sun. From reports of annual meetings in the papers of other companies, I know others charge no extra premium. With applicants for new policies in the time of war the question must be different.

My information may be of service to some holding pre-war policies; but the proper way is to get a reply from the head office stating the privilege.

Yours, etc.,

POLICY-HOLDER.

15th April, 1916.

[As was stated in our article on this subject, the question whether an extra premium is required on old policies depends on whether a restricting clause had been included in the policy. The majority of English and Scottish offices have been in the habit of including clauses of this nature in ordinary policies. It is a scarcely a matter of privilege.]

A LINK WITH THE PAST.

Sir,—I have found two letters from Mr. Joseph Lister, afterwards Lord Lister, when he was at Glasgow, addressed to me when I was Resident Surgeon to the Poplar Hospital, London, in reply to mine, asking whether carbolic acid would be suitable to use in my own case, ear-discharge following scarlet fever in infancy. They are as follows:—

17 Woodside Place,
Glasgow,
29th April, 1869.

In reply to your enquiry, I am sorry to say I fear the antiseptic system is little applicable to your case. However, there could be no harm in giving a trial to the following plan: Syringe the ear with a watery solution of the acid, say 1 part of acid to 40 of water, and then introduce into the meatus auditorius a piece of cotton wool moistened with an oily solution of the acid, say 1 part of acid to 20 of oil. This to be done pretty often, say every four hours. If at the end of a week the complaint is not benefited, you might assume that the source of the discharge was something which the injection could not reach. Should a cure, on the other hand, result, I should be very glad if you would communicate to me the fact.

Yours very truly,
(Signed) JOSEPH LISTER.

I tried the plan for a short time, but, as he expected, did not improve under it, and wrote to him, saying that I was going to Australia and he replied:—

17 Woodside Place,
Glasgow,
8th June, 1869.

My Dear Sir,—I am very sorry to hear of the troubles you have had with your ears. Sincerely hoping that you will derive great benefit from your voyage to Australia, and that you may also get quit of the otorrhœa,

I remain, Yours very truly,
(Signed) JOSEPH LISTER.

Next month I sailed as surgeon to Messrs. Green's ship *Highflyer*, and although the discharge ceased some years after, I cannot say the left ear is no trouble, although it is nearly 47 years since I came out here.

Yours, etc.,

O. PENFOLD.

Bendigo, 2nd April, 1916.

Proceedings of the Australasian Medical Boards.

NEW SOUTH WALES.

The following have been registered under the provisions of the "Medical Act, 1912, 1915," as duly qualified medical practitioners:—

Braby, Arthur, M.B., 1916, Univ. Sydney.
Bruce, Herbert George Burnett, M.B., M.S., 1916, Univ. Sydney.
Burkitt, Arthur Neville St. George Handcock, M.B., 1916, Univ. Sydney.
Clark, Harold Picton, M.B., 1916, Univ. Sydney.
Daniel, Phillip Lisle, M.B., 1916, Univ. Sydney.
Frecker, Eric Wilfred, M.B., 1916, Univ. Sydney.
George, Sydney, M.B., M.S., 1916, Univ. Sydney.
Harrison, Nellie Atkinson, M.B., M.S., 1916, Univ. Sydney.
McDonald, Charles George, M.B., 1916, Univ. Sydney.
McKenzie, Arthur Duncan, M.B., 1916, Univ. Sydney.
Maclean, Jonathan Murray, M.B., 1916, Univ. Sydney.
Matheson, Christopher Norman, M.B., 1916, Univ. Sydney.
Morris, Percy Alexander, M.B., M.S., 1916, Univ. Sydney.
Parr, Thomas Liddon, M.B., M.S. 1916, Univ. Sydney.
Rodda, Frank Neil, M.B., M.S., 1916, Univ. Sydney.
Smith, John William, M.B., 1916, Univ. Sydney.
Symonds, Hyman, M.B., 1916, Univ. Sydney.
Templeman, Colin Gordon, M.B., M.S., 1916, Univ. Sydney.
Traill, Alan James, M.B., M.S., 1916, Univ. Sydney.
Young, William Rae, M.B., 1916, Univ. Sydney.
Noble, Hubert Arthur Edgar, L.R.C.P. (Edin.), 1892; L.R.C.S. (Edin.), 1892; L.F.P.S. (Glasg.), 1892.
Phippen, Harry Garnett, L.R.C.P. (Lond.), 1906; M.R.C.S. (Eng.), 1906.
Samson, Cedric Murray, M.B., M.S., 1915, Univ. Sydney.

For additional registration:—

Bateman, Charles Daubeny, M.S., 1916, Univ. Sydney.
Hill, John Goodwin Watson, M.S., 1916, Univ. Sydney.
Simmons, William Foster, M.S., 1916, Univ. Sydney.

VICTORIA.

The following have been registered under the provisions of Part I. of the "Medical Act, 1915" as legally qualified medical practitioners:—

Florey, Hilda Josephine, M.B. et Ch.B., Adelaide, 1912.
Mondon, Vilcourt Pierre, M.B. et Ch.B., Edin., 1910.

Medical Appointments.

Dr. J. S. McLean has been appointed Officer of Health for the East Riding of the Dunmunkle Shire, Victoria.

Dr. A. A. Weir has been appointed Acting Officer of Health for the Mortlake Shire, Victoria.

Dr. Peter Lalor has resigned his position as Junior Medical Officer at the Hospital for the Insane at Royal Park, Victoria.

Dr. F. J. R. Cade, of Narrabri, has been appointed a Commissioner of the Peace for the State of New South Wales.

The retirement of Dr. Joseph A. Beattie from the position of Senior Medical Superintendent of the Liverpool State Hospital and Asylum has been accepted. Dr. Beattie relinquished his duties on April 13, 1916.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xv.

Texas District Hospital, Queensland, Medical Officer.
Brisbane Hospital, Resident Medical Officer.
Western Australia, Medical Officer of Health.
General Hospital, Hobart, Junior House Surgeon.
Cue Day Dawn, W.A., Medical Officer.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—New Appointments as Medical Officer, Ophthalmic Surgeon, Ear, Nose and Throat Surgeon, Physician. Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Goulburn F.S. Association. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute. Croydon Hospital. Laidley Hospital, Medical Officer.
WESTERN AUSTRALIA. (Hon. Sec., 230 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
NEW ZEALAND: WELLINGTON DIVISION. Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

Apr. 25.—N.S.W. Branch, B.M.A., Medical Politics Committee, Organization and Science Committee.
Apr. 26.—Vic. Branch, B.M.A., Council.
Apr. 27.—South Aust. Branch, B.M.A., Branch.
Apr. 27.—Sydney University Medical Society, Annual Meeting.
Apr. 28.—N.S.W. Branch, B.M.A., Ordinary.
May 3.—Cent. South. Med. Assoc. (N.S.W.).
May 3.—Cent. West. Med. Assoc. (N.S.W.).
May 5—Q. Branch, B.M.A., Branch.
May 9.—N.S.W. Branch, B.M.A., Ethics Committee.
May 9.—Tas. Branch, B.M.A., Council and Branch.
May 11.—Vic. Branch, B.M.A., Council.
May 12.—N.S.W. Branch, B.M.A., Clinical Evening.
May 12.—South Aust. Branch, B.M.A., Council.
May 16.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
May 17.—West Aust. Branch, B.M.A., General.
May 19.—Q. Branch, B.M.A., Council.

EDITORIAL NOTICES.

The following journals are missing from the Library of the Victorian Branch of the British Medical Association. The Librarians will be indebted to any member who will give or sell any or all of the numbers.

Lancet, October 3 and May 29, 1915.

Edinburgh Medical Journal, December, 1915.

Universal Medical Record, May, 1914, title page and index of Part I., 1914, January, 1915.

Annals of Surgery, April, August, October, 1911.

Glasgow Medical Journal, October, 1912.

Birmingham Medical Review, January, July, 1903, November, 1904, March, 1911, August, October and December, 1912, and title page and index, Parts I. and II., 1912, January and February, 1913, April, May and November, 1914, title page and index, Parts I. and II., 1914, January and April, 1915.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrury be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.